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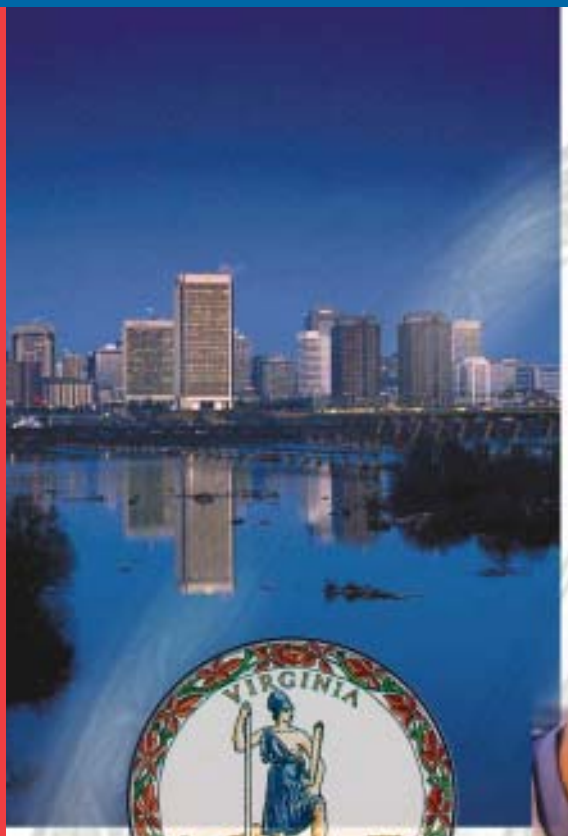

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Optima Family Care

Annual Report 2005

We don't provide healthcare... we make it better.

Optima Family Care Annual Report

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva has conducted a comprehensive review of Optima Family Care (Optima) to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition

of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the goals of DMAS. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

Although Delmarva's task is to assess how well Optima performs in the areas of quality, access, and timeliness from Health Employer Data and Information Set (HEDIS®[1]) performance, performance improvement projects, and operational systems review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report.

Background on Plan

Optima provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia. Enrollment in 2004 for Optima health plan was 111,166 members. Localities covered by Optima are Tidewater, Central Virginia, Charlottesville, and Halifax regions. Optima began providing services to Medallion II enrollees in January 1996 and is an NCQA-accredited health plan with an excellent accreditation status.

Data Sources

Delmarva has used the following three data sources to evaluate Optima's performance:

- HEDIS performance measures, which are a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.
- Summaries of plan-conducted Performance Improvement Projects (PIPs).
- Operational systems review consisting of a desk review conducted by Delmarva as the EQRO to reassess deficient elements from the previous year's onsite review for compliance with contract requirements and state regulations.

[1] HEDIS ® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Methodology

Delmarva performed an external independent review of all data from the above-listed sources. The EQRO has assessed quality, access, and timeliness across the three data disciplines. After discussion of this integrated review, Delmarva will provide an assessment to DMAS regarding how well the health plan is providing quality care and services to its members.

Health plan HEDIS results are audited by NCQA-licensed organizations. The HEDIS data in this report have been audited by MedStat through Delmarva. The BBA requires that performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Each audit was conducted as prescribed by NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and is consistent with the validation method required by the EQRO protocols. NCQA protocols are used to capture and compute HEDIS results. This report contains data results of common HEDIS measures, each of which is calculated by all Medallion II managed care plans[2].

During the HEDIS 2005 reporting year, Optima collected data from calendar year 2004 related to the following clinical indicators as an assessment of quality, access, and timeliness:

- Childhood Immunization Status
- Adolescent Immunization Status
- Breast Cancer Screening
- Prenatal and Postpartum Care
- HEDIS/CAHPS 3.0H Adult Survey
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visit

PIPs also are used to assess the health plan's focus on quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to the identification of issues regarding access or timeliness as major contributing factors that affect the attainment of the clinical quality goals. Optima submitted two PIPs for review. Delmarva reviewed the health plan's PIPs, assessed compliance with DMAS contractual requirements, and validated the activity for interventions as well as evidence of improvement. The PIP topics were as follows:

- Improving Overall Treatment and Utilization Patterns for the Sentara Health Management Asthma Population
- Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population

[2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

The Optima Operational Systems Review covered activities performed during the time frame of Jan. 1, 2004 through December 31, 2004 and focused on elements which were found to be deficient (elements partially met or not met) in the previous years' onsite review. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq.* In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Quality At A Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. These indicators along with access and timeliness are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population. The findings related to quality are displayed in the following sections.

HEDIS

Three HEDIS measures served as proxy measures for clinical quality:

- Childhood Immunizations
- Adolescent Immunizations
- Breast Cancer Screening

Table 1 shows the results obtained by Optima.

Table 1. 2005 HEDIS Quality Measure Results for Optima

HEDIS Measure	2005 Optima Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Childhood Immunization Status	59.1%	58.1%	61.8%
Adolescent Immunization Status	62.7%	49.7%	51.8%
Breast Cancer Screening	59.0%	51.4%	55.8%

Optima exceeded the Medallion II average for all three quality measures. Optima also exceeded the National Medicaid HEDIS average for two measures. The "Childhood Immunization Status" rate fell slightly below the National Medicaid HEDIS average (59.1% versus 61.8%). The results show strengths with regard to these areas of quality.

Performance Improvement Projects

In the area of PIPs, Optima used the quality process of identifying a problem relevant to its population, setting a measurement goal, obtaining a baseline measurement, and performing targeted interventions aimed at improving the performance. After the remeasurement periods, qualitative analyses often identified new barriers that affect success in achieving the targeted goal. Thus, quality improvement is an ever-evolving process focused on improving outcomes and health status.

Optima has implemented two PIPs:

- Improving Overall Treatment and Utilization Patterns for the Sentara Health Management Asthma Population
- Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population

Optima's PIP aimed at improving overall treatment and utilization patterns for the Sentara Health Management asthma population addresses an important opportunity for improvement for Optima's member population based upon review of Medicaid HMO plan specific and national data. Asthma ranked in the top diagnoses for inpatient and emergency room admissions and continued increases were evidenced in the number of enrollees with asthma.

Optima's PIP related to improving overall treatment and utilization patterns for the Sentara Health Management asthma population *seeks* to decrease emergency room and hospital admissions for Medallion II enrollees who have been diagnosed with asthma. The PIP also includes a goal to increase the use of appropriate asthma medications This PIP, over time, addresses multiple care and delivery systems that have the ability to pose barriers to improved enrollee outcomes. Use of appropriate asthma medications has been

demonstrated to improve long-term control for individuals with asthma and, as such, serves as a proxy measure for changes in health status.

Optima conducted analysis and developed related interventions for each enrollee, provider, and administrative barrier identified. Interventions have focused on both patient and provider education and effective communication strategies as well as streamlining the referral process for providing case management services to high risk enrollees by contracting with one statewide agency.

A comprehensive quantitative analysis was performed following each re-measurement that compared result to goal/benchmark and prior performance, described reasons for any changes to goals, and identified any trends or changes in statistical significance. The analysis included an assessment of the success of each indicator relative to the goal established. For the inpatient hospital admission indicator the goal was met demonstrating a 5% improvement over the prior period. For the emergency department visit indicator the rate exceeded the goal with a 7% decrease in emergency department visits over the prior period. For the appropriate asthma medication indicator the rate fell slightly short of the goal with slight deterioration in performance from the prior period.

Optima also implemented a PIP related to improving treatment and utilization patterns for the Sentara Health Management diabetes population. Optima analyzed its Medallion II demographic and utilization data and compared performance on select measures with national data. Optima, in its analysis, identified that diabetes rates for the Medicaid population increased by 11% overall and by 16% in the 0-17 age population in 2004. Additionally, overall diabetes prevalence rates have increased across the state of Virginia and in ethnic groups, low-income populations, and females. Optima further identified that diabetes rates have continued to be in the top ten diagnoses for the health plan for all claims by cost and volume.

Optima, through its PIP related to improving treatment and utilization patterns for the Sentara Health Management diabetes population, seeks to improve six HEDIS comprehensive diabetes care rates as well as to decrease the inpatient admission and emergency department visit rates for a primary diagnosis of asthma. While this is considered to be a baseline review, and assessment of the MCO's prior performance was not conducted, this PIP did address over time multiple care and delivery systems that have the ability to pose barriers to improved enrollee outcomes. Decreased inpatient admissions and emergency department visits, as well as improvement in comprehensive diabetes care, have been identified as valid proxy measures for improved health status.

Enrollee/family, provider, and administrative barriers were identified by Optima. Education and outreach targeted at enrollees and providers on appropriate diabetes management, telemanagement outreach to enrollees with diabetes related hospital admissions and emergency departments visits, and removal of a

requirement for primary care provider referral for dilated eye exam were implemented and appear to be reasonable interventions based upon the barriers identified.

Table 2 provides a summary of data results for both PIPs conducted by Optima.

Table 2: PIP Performance Results

PIP Activity	Indicator	Baseline	Remeasurement				
			#1	#2	#3	#4	#5
Improving Overall Treatment and Utilization Patterns for the Sentara Health Management Asthma Population	Quantifiable Measure #1: Percent of continuously enrolled Medicaid HMO enrollees with an inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) Quantifiable Measure #2: Percent of continuously enrolled Medicaid HMO enrollees with an emergency department visit for a primary diagnosis of asthma (ICD9 493.0-493.92) Quantifiable Measure #3: Percent of continuously enrolled members with asthma in the prior year that received an appropriate prescription in the reporting year. For this measure Asthma is defined as a member who meets one of the following criterion in the prior year: 4 or more asthma medication dispensing events 1 or more Emergency	1999: QM1:5.5% QM2: 26.2% QM3: 58.82%	2000: QM1: 5.0% QM2: 21.2% QM3: 61.42%	2001: QM1: 4.6% QM2: 18.3% QM3: 67.81%	2002: QM1: 4.0% QM2: 20.2% QM3: 69.62%	2003: QM1: 4.4% QM2: 22.3% QM3: 68.24%	2004: QM1: 4.1% QM2: 20.7% QM3: 67.66%

PIP Activity	Indicator	Baseline	Remeasurement				
			#1	#2	#3	#4	#5
	Department visits for asthma 1 or more inpatient admissions for asthma 4 outpatient visits AND 2 or more asthma Rx dispensing events						
Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population	<u>Quantifiable Measure #1:</u> Hemoglobin A1c Test Rate <u>Quantifiable Measure #2:</u> Retinal Eye Examination Rate <u>Quantifiable Measure #3:</u> LDL screening rate <u>Quantifiable Measure #4:</u> LDL control rate <130 mg/dL <u>Quantifiable Measure #5:</u> Nephropathy Monitor Rate <u>Quantifiable Measure #6:</u> A1c Poor Control Rate <u>Quantifiable Measure #7</u> Rate of inpatient admissions for a primary diagnosis of diabetes with continuous enrollment for the period. <u>Quantifiable Measure #8</u> Rate of emergency department visits admissions for a primary diagnosis of diabetes with continuous enrollment for the period.	2000: QM1: 64.89% QM2: 47.22% QM3: 53.27% QM4: 30.99% QM5: 30.27% QM6: 59.81% QM7: 9.4% QM8: 7.2%	2001: QM1: 68.92% QM2: 50.32% QM3: 57.72% QM4: 34.25% QM5: 35.31% QM6: 64.48% QM7: 7.1% QM8: 6.2%	2002: QM1: 75.44% QM2: 46.05% QM371.93% QM4: 45.18% QM5:40.13% QM6: 48.68% QM7: 5.7% QM8: 7.4%	2003: QM1: 73.54% QM2: 38.11% QM3: 73.79% QM4: 49.51% QM5:36.17% QM6: 42.96% QM7: 5.4% QM8: 7.1%	2004: QM1: 73.41% QM2: 41.98% QM3: 72.09% QM4: 55.16% QM5:37.58% QM6: 47.47% QM7: 5.1% QM8: 6.6%	

Operational Systems Review Findings

Within the operational systems review component of the quality review, Optima was reassessed specifically in the following areas:

Enrollee Rights and Protections—Subpart C Regulations

- ER1. Enrollee Rights and Protections-Staff/Provider

Quality Assessment and Performance Improvement —Subpart D Regulations

- QA5. 438.206 (c) (2) Cultural Considerations
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests
- Q24. 438.236 (c) Dissemination of Practice Guidelines
- QA28. 438.240 (b) (3) Basic Elements of Quality Assessment and Performance Improvement (QAPI) Program—Special Health Care Needs
- QA29. 438.242 Health/Management Information Systems

Grievance Systems—Subpart F Regulations

- GS1. 438.402 (a,b) Grievance System
- GS3. 438.404 Notice of Action
- GS4. 438.404 (b) Content of Notice of Action

Optima performed well in the areas of enrollee rights and protections- staff/provider, cultural considerations, dissemination of practice guidelines, basic elements of QAPI program, health/management information systems, and content of notice of action. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where Optima has performed successfully in this review is with cultural considerations. Optima has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds. However, it is recommended that Optima revise relevant policies to include procedures for evaluating the effectiveness of the interventions in promoting the delivery of services in a culturally competent manner to enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds. The area of dissemination of practice guidelines was found to be another core strength for Optima. Optima has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

Optima was found to have opportunities for improvement in the areas of coverage and authorization of services, grievance systems and, notice of action. For coverage and authorization of services relating to the monitoring of the application of review criteria for authorizations and taking corrective action to ensure consistent application; a recommendation was provided. The recommendation for improvement suggests that Optima develop a more formalized process for assessing inter-rater reliability among its physician review

staff including minimum thresholds for performance and corrective action if indicated. There should be evidence of formal reporting of results for both physician and non-physician review staff to the appropriate committee on at least an annual basis. An additional recommendation pertaining to grievance systems suggests that Optima provide evidence of an annual review of all subcontractors' grievance and appeal policies and procedures to determine compliance with DMAS requirements as outlined in the contract modifications of July 2003. If they are determined to be out of compliance there should be evidence of a successful corrective action plan to bring them into compliance.

Five elements were partially met and six elements changed to met status since the last review. There were no unmet elements found in the review. Most of the improvement areas were addressed within twelve months of the audit review period. Optima effectively implemented the recommendations for quality improvement and corrected each area by this review period. The rapid correction of the previous review's opportunities for improvement is evidence that Optima has a strong oversight process and commitment to improving care and services to its members.

Summary of Quality

Optima demonstrates a quality-focused approach in administering care and services to its members. The plan exhibits an integrated approach to working with its members, practitioners, providers, and internal health plan departments to improve overall health care quality and services. The health plan also focuses resources toward evaluating the interventions that provide the most benefit toward improvement needs. Opportunities for improvement may be evident in the area of quality pertaining to HEDIS measures and reassessed elements from the operational systems review.

Access At A Glance

Access to care and services historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. Access is an essential component of a quality-driven system of care. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access are discussed in the following sections.

HEDIS

From a HEDIS perspective, access and availability of care are addressed through the Prenatal and Postpartum Care HEDIS measure. Two rates are calculated for this measure:

- Timeliness of Prenatal Care
- Postpartum Check-up Following Delivery

Table 3 shows the results obtained by Optima.

Table 3: 2005 HEDIS Access Measure Results for Optima

HEDIS Measure	2005 Optima Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Timeliness of Prenatal Care	82.7%	82.8%	76.0%
Postpartum Check-up Following Delivery	59.7%	57.8%	55.2%

Optima scored above the Medallion II average and the National Medicaid HEDIS average for the "Postpartum Check-up Following Delivery" rate. The "Timeliness of Prenatal Care" rate fell slightly below the Medallion II average; however the Optima rate exceeded the National Medicaid HEDIS average by several percentage points. Postpartum care is impacted by the health plan's access to correct demographic information for outreach to postpartum members. These results regarding access appear to be strengths for Optima.

Performance Improvement Projects

Optima's PIPs focused upon improvement of clinical indicators. However, within the barrier analyses for each project, potential access barriers were also examined. The identification of access barriers was found in Optima's PIPs aimed at improving overall treatment and utilization patterns for the Sentara Health Management asthma and diabetes populations.

Barriers were identified related to member and provider lack of awareness of benefits regarding chronic diseases like asthma and diabetes. In 2004, interventions focused on both patient and provider education and effective communication strategies as well as streamlining the referral process for providing case management services to high risk enrollees by contracting with one statewide agency to improve member outcomes.

Operational Systems Review Findings

Delmarva's operational systems review of Optima showed that the following review requirements were reexamined and reflected adequate proxy measures for access:

Enrollee Rights and Protections—Subpart C Regulations

- ER3. Information and Language Requirements (438.10)
- ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)
- ER7. Rehabilitation Act, ADA

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA1. 438.206 Availability of Services (b)

Through a desk review conducted for Optima, Delmarva comprehensively reassessed elements from the previous year's review that were deficient and found that three of the areas have improved to met status within the year prior to this review. Optima performed well in the areas of information and language requirements, emergency and post-stabilization services, and availability of services. Policies and procedures were revised prior to this review to ensure compliance within these areas.

An example of a significant area where Optima has performed successfully in this review is with information and language requirements. Optima has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. An additional area of strength for Optima is with emergency and post-stabilization services. Optima has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed. A final area of strength for Optima pertains to the availability of services. Optima has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their primary care provider (PCP) be a specialist.

Only two elements were partially met for this review and pertain to information and language requirements and the Rehabilitation Act. One element was found to be unmet in the area of emergency and post-stabilization services. For information and language requirements relating to policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats; a recommendation was provided. The recommendation for improvement suggests that Optima revise the above policy to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats. Subsequent to the review Optima submitted a revised Interpreter and Translation Services policy that will be assessed for compliance in the next EQRO review.

The recommendation regarding the Rehabilitation Act and compliance with Federal and State laws regarding enrollee confidentiality is for Optima to furnish compliance monitoring policies as well as written documentation of formal compliance audits, findings, and any recommendations or corrective action plans for the review period that demonstrate implementation of these policies throughout the MCO. The final recommendation given for the unmet element pertaining to emergency and post-stabilization services was for Optima to provide enrollees with locations of settings that furnish emergency and post-stabilization services covered by the MCO. Optima should add information in either the Provider Directory or the enrollee handbook on where to obtain post-stabilization services. Subsequent to the review, Optima submitted revised language to be included in the member handbook, which will be assessed for compliance in the next EQRO review.

After completion of the review, Delmarva conducted an assessment of Optima corrective action process. Optima effectively implemented recommendations related to elements found to be partially met or not met and corrected many of the elements within twelve months of the report findings.

Summary of Access

Overall, access is an area of strength for Optima and supports the health plan's intent as a quality-driven system of care. Combining all the data sources used to assess access; Optima addressed the areas where the health plan showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness At A Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. All Medallion II managed care plans were required to submit these measures.

HEDIS

Timeliness of care was investigated in the results of the following HEDIS measures:

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visits

Table 4 shows the results obtained by Optima.

Table 4: 2005 HEDIS Timeliness Measure Results for Optima

HEDIS Measure	2005 Optima Rate	Medallion II Average	2004 National Medicaid HEDIS Average
Well Child Visits in the First 15 Months of Life - 6 or more visits	41.1%	35.0%	45.3%
Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	60.5%	59.7%	60.5%
Adolescent Well-Care Visits	27.9%	31.0%	37.4%

The "Well Child Visits in the First 15 Months of Life" and the "Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life" measures exceeded the Medallion II average. However, the "Adolescent Well-Care Visits" measure fell below both comparison averages.

Performance Improvement Projects

Timeliness was a focal area of attention in Optima's PIPs. Member focused efforts consisted of assuring that members were educated about key feature of diabetes disease management and asthma. Barriers related to timeliness issues focus upon the lack of timely provision of care or services due to missed opportunities.

Issues related to timeliness of services may very likely be impacted by access. Optima's PIPs, aimed at improving overall treatment and utilization patterns for the Sentara Health Management asthma and diabetes populations, are HEDIS-related and focus upon services received (access) as well as the timeframes in which the services were provided (timeliness).

Operational Systems Review Findings

Delmarva's desk review findings showed that the following review requirements were reassessed and reflect adequate proxy measures for timeliness:

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests
- QA14. 438.210 (d) (2) Timeframe for Decisions—Expedited Authorization Decisions

Grievance Systems—Subpart F Regulations

- GS7. 438.408 Resolution and Notification: Grievances and Appeals—Standard Resolution
- GS10. 438.408 (c) Requirements for State Fair Hearings

Optima performed well in the areas of coverage and authorization of services, resolution and notification: grievances and appeals, and requirements for state fair hearings. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where Optima has performed successfully in this review is with coverage and authorization of services. Optima has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services and basic prenatal care. Another area of strength for Optima relates to resolution and notification. In cases of appeal decisions not being rendered within 30 days, Optima provides a written notice to the enrollee.

Delmarva identified two elements pertaining to coverage and authorization of services and timeframes for decisions that were found to be unmet after this review. Neither of these elements demonstrated improvement from the last review. A recommendation for coverage and authorization pertaining to

subcontractor's utilization management plan submission annually and upon revision was provided. In order to receive a finding of met, it is recommended that Optima provide copies of utilization management plans from each subcontractor's delegated utilization management (UM) activities for the time frame reviewed, with evidence that an annual review of each utilization management plan was conducted by the appropriate committee. The final recommendation in regards to timeframes for decisions is for Optima to revise the Services Requiring Authorization and Timeframes for Decisions policy to include the extension time frame for expedited authorizations provided in the Medallion II Managed Care Contract. A revised Services Requiring Authorization and Timeframes for Decisions policy was subsequently submitted and will be assessed for compliance in the next EQRO review.

Optima effectively addressed the other four elements identified as deficient in the previous review, which have all now evolved to met status. Optima corrected most of the timeliness related deficiencies within twelve months, which displays their commitment to continuous improvement.

Summary for Timeliness

Optima demonstrates an awareness of the importance of timeliness in the delivery of overall quality care and service through the identification of timeliness barriers, which often are identified as access issues. Optima is encouraged to continue to address opportunities for improvement in the area of timeliness.

Overall Strengths

Quality:

- Commitment of Optima management staff towards quality improvement as evidenced by the rapid response and resolution of most deficiencies cited during the operational systems review.
- Optima met the majority of the re-assessed quality elements for the operational systems review.
- Information system capabilities for performance measures to include data capture, general information systems, centralized processing of data, provider data, data sharing, and eligibility programming.
- Reporting methods for performance measures include staff experience, communication, documentation, and a team approach.
- Improvements realized since baseline related to asthma's inpatient hospital and emergency department indicators and the use of appropriate medications for people with asthma were sustained and the disease management program interventions implemented by Optima to address barriers identified positively impacted care over time.

Access:

- Optima demonstrates equivalent or better access to prenatal care and postpartum follow-up than the Medallion II program in aggregate and the Medicaid program nationally.
- Recognition by Optima that quality of care issues are impacted by access barriers.

Timeliness:

- Optima met the majority of the re-assessed timeliness elements for the operational systems review.
- Optima's partnership with the practitioner network to address education about asthma and diabetes in the member population.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for Optima are as follows:

- Optima is encouraged to continue efforts to increase data completeness.
- Optima is encouraged to continue employing successful performance measure reporting tactics.
- General quality improvement and teamwork training is also recommended as these skills will likely lead to efficiencies in performance measure reporting.
- Improve documentation of processes and methodologies to assist during staff changes would be beneficial.
- Develop standardized provider data entry protocols and methodologies to identify locations of member medical records could reduce the need for multiple unsuccessful medical record chases.
- Develop or revise policies and procedures of the elements found to be deficient and/or make appropriate improvements in order for the deficiencies to be met in next year's EQRO review.
- Perform periodic monitoring within the areas identified in the operational systems review as deficient to make certain that the actions undertaken to correct the issues remain effective.
- Perform further investigation of low rated measures identified by HEDIS.
- Assess the disparities in quality of care and/or services among differing ethnic population within the managed care membership. Understanding this phenomenon will enable focused resource allocation.
- Perform root cause analyses for project interventions that fail to improve performance. This activity will enable Optima to better identify barriers to change and more effectively allocate resources to achieve systemic improvements.

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